Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.** See **Part B - Termination** on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death — Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name — Date of birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (**Note:** This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number
	Payroll contact and telephone number
Signature of authorized agency official	Date 07/19/99

Copy 1 - To Enrollee

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.** See **Part B - Termination** on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death — Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name — Date of birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below.
(**Note:** This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number
	Payroll contact and telephone number
Signature of authorized agency official	Date 07/19/99

Copy 2 - To Insurance Carrier

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.** See **Part B - Termination** on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death — Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name — Date of birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below.
(**Note:** This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number
	Payroll contact and telephone number
Signature of authorized agency official	Date 07/19/99

Copy 3 - To Payroll Office

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.** See **Part B - Termination** on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death — Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name — Date of birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (**Note:** This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number
	Payroll contact and telephone number
Signature of authorized agency official	Date 07/19/99

Copy 4 - For Official Personnel Folder